STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445358	A. BUILDING _____ B. WING _____	C 10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEBRIDGE HEALTH CARE CENTER	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Lakebridge Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Lakebridge Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal, and any other applicable legal or administrative proceedings. This plan of correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable in administrative, civil or criminal proceedings.	10/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nyda Bays — TITLE: Administrator — (X6) DATE: 10/27/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 31 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, and interview, the facility failed to implement measures to prevent the spread of infection for three residents (#1, #2, #5) of five sampled residents. The findings included: Review of facility policy revealed, "Title ...Perineal Care ...will be provided as needed ...Procedure ...Female ...Assist the Resident to a supine (lying on back with face up) position...spread legs ...from the front to the back ...Position the Resident on ...side ...to expose the anal area ...Clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back ...Assist ...to a comfortable position ... Remove gloves and discard ...Wash hands ..." Review of facility policy revealed, "Title ...Hand Washing...This facility considers hand washing to be the single most important factor in the control of infection ...shall utilize proper hand washing for each of the following conditions: ...After contact with a resident ...After contact with Resident-contaminated supplies and equipment ...Before and after incontinence care ...The use of gloves does not replace hand washing. Once gloves are removed, proper hand washing should be performed ..." Review of facility policy revealed, "Title ...General Policies ...Infection Control: Necessary housekeeping personnel are provided to maintain the facility in a clean, sanitary ...manner to help prevent the development and transmission of infection ..."	F 441	F441 **Corrective Actions for Targeted Residents:** 10/19/2011 C.N.A's# 1 and # 2 were immediately counseled and inserviced on the Hand Washing and Infection Control Policy by the Director of Nursing. . Housekeeper was counseled and inserviced on Hand Washing by the Housekeeping Supervisor. . **Identification of Other Residents with Potential to be Affected** Due to the nature of this practice, current residents have the potential to be affected. **Systematic Changes** Immediately on 10/19/2011 the Director of Nursing completed an inservice on Handwashing with current employees and on 10/28/2011 the Director of Nursing, held a mandatory inservice on infection control and handwashing for current staff to ensure that policy on handwashing and infections control were followed.	

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F 441	Continued From page 2 Resident #1 was admitted to the facility on June 13, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease and Infection of Kidney Unspecified. Medical record review of the Minimum Data Set dated September 26, 2011, revealed the resident had a history of a urinary tract infection within the previous thirty days. Observation of perineal care with Certified Nursing Assistants (CNA) #1 and #2 on October 19, 2011, at 12:45 p.m., revealed the CNAs assisted the resident to the left side. Continued observation revealed CNA #2 washed the resident's buttocks with downward strokes of the washcloth from the resident's right upper buttock toward the thigh, obtained another wash cloth and used the same motion on the resident's left buttock, and placed the soiled linen in a plastic bag on the bed. Continued observation revealed the CNAs positioned the resident on the back, CNA #1 completed the perineal care and placed the bag of soiled linen on the floor. Continued observation revealed the CNAs washed their hands, CNA #2 repositioned the resident, touched the resident and bed linen with ungloved hands. Continued observation revealed CNA #1 touched the resident's siderail with ungloved hands, disposed of the soiled linen bag, and both CNAs left the resident's room without washing their hands. Interview with CNAs #1 and #2 on October 19, 2011, at 1:02 p.m., in the 700 hallway, confirmed neither CNA wore gloves or washed their hands as required per facility infection control policy.	F 441	**Monitoring** The Director of Nursing, and Housekeeping Supervisor will monitor to ensure that proper infection control is being followed when pericare is being preformed and housekeeping is not touching objects with contaminated gloves. The practice will be monitored on a weekly basis X 3 months. The Housekeeping Supervisor and Director of Nursing will report finding to the Performance Improvement Committee for review and determination of on-going compliance. This committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS & Assessment Nurse, Housekeeping Supervisor, Maintenance Director, Social Services Director, and other Administrative staff as appropriate to audit areas and outcomes. The Committee's recommendations will be followed up by the Administrator and the Director of Nursing.	

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F 441	Continued From page 3 Resident #5 was admitted to the facility on September 20, 2011, with diagnoses including Urinary Frequency. Observation on October 19, 2011, between 9:30 a.m. and 10:14 a.m., revealed Housekeeper #1 exited another resident's room, entered Resident #5's room and and performed cleaning tasks and exited the resident's room two times during the cleaning procedure without washing her hands. Resident #2 was admitted to the facility on March 18, 2011, with diagnoses including Personal History of Urinary Tract Infection. Medical record review of a urine culture dated September 3, 2011, revealed the resident had a urinary tract infection and included, " ...>100, 000 e coli ..." Medical record review of the MDS dated September 30, 2011, revealed the resident required extensive assistance with hygiene and was incontinent of bowel and bladder. Observation on October 19, 2011, at 10:14 a.m., revealed Resident #2 sitting in a wheelchair next to a janitor's room; Housekeeper #1 grasped the resident's wheelchair and moved the resident away from the janitor's room; observation revealed the housekeeper had entered and exited two other residents' rooms without washing her hands prior to touching Resident #2's wheelchair. Interview with Housekeeper #1 on October 19, 2011, at 10:15 a.m., in a janitor's room, revealed she had been taught how to prevent the spread of infection, and she stated, " ...supposed to wash your hands every time you leave a room ..."	F 441		

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F 441	Continued From page 4 Interview with the Director of Nursing on October 19, 2011, at 1:25 p.m., in a conference room, confirmed the facility had failed to provide a sanitary environment to help prevent development/transmission of infection for Residents #1, #2, and #5. C/O: #28676	F 441	F514 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors the facility is taking the following additional actions.	10/31/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete, accurate medical record for one resident (#4) of five sampled residents. Th findings included: Resident #4 was admitted to the facility on January 4, 2011, with diagnoses including Acute	F 514	**Corrective Actions for Targeted Residents** The discharge summary of the medical record was completed by Interdisplinary team on 10/20/2011 to ensure that the medical record was complete and accurate for resident # 4. **Identification of Other Residents with Potential to be Affected** Medical record clerk will audit 3 months of discharge residents medical records for incompletness of discharge summaries. This audit will be reviewed by the Administrator Administrator will ensure that medical records discharge summaries are completed by the Interdisplinary Team to maintain a complete, accurate medical record. **Systematic Changes** 10/28/2011 Nursing staff and Inter - displinary team inserviced to ensure that any discharged record is complete and accurate.	

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F 514	Continued From page 5 Respiratory Failure. Medical record review of a nurse's note dated January 9, 2011, revealed the resident was admitted to a hospital with abdominal pain. Medical record review of a Discharge Summary dated January 9, 2011, revealed the the "Physical Assessment on Discharge" including the medical reason for discharge, a summary of diagnoses and/or other conditions at the time of discharge, and the physician's signature had not been completed. Continued review revealed the "Medical Status Measurement" including laboratory reports/diagnostic reports and/or the resident's discharge vital signs had not been completed. Interview with the medical record supervisor on October 19, 2011, confirmed the facility failed to maintain a complete, accurate medical record for Resident #4.	F 514	**Monitoring** Discharged Records will be reviewed by Director of Nursing, Assessment Nurse and MDS Coordinator to assure ongoing compliance. The results of the performance audit will be submitted monthly by Director of Nursing to the Performance Improvement Committee. This committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS & Assessment Nurse, Housekeeping Supervisor, Maintenance Director, Social Services Director, and other Administrative staff as appropriate to audit areas and outcomes. The Committee's recommendations will be followed up by the Administrator and the Director of Nursing.	